STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155779	A. BUILDING 00 B. WING	06/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BOULEVARD EA NOBLESVILLE, IN46060

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R0000	This visit was for Investigation of Complaint IN00091241. Complaint IN00091241: Substantiated. State deficiencies related to the allegations are cited at R002 and R217 Date of survey: June 8, 2011 Facility number: 012305 Provider number: 155779 AIM number: N/A Survey team: Vanda Phelps, RN Census bed type: 48 SNF 51 Residential 109 Total Census payor type: 28 Medicare 1 Other 109 Total Sample: 3 These state findings are cited in accordance with 410 IAC 16.2-5.	R0000	**Prairie Lakes Health Campus submits this plan of correction in response to the state requirement deficiencies cited during the Complaint Survey conducted on June 8, 2011.** **Please accept this plan of correction as the providers letter of credible allegation of compliance effective July 8, 2011.** **We respectfully request paper compliance for this plan of correction.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0002	Quality review 6/13/11 by Suzanne Williams, RN (b) A residential care facility may not provide comprehensive nursing care except to the extent allowed under this rule. Based on observation, interview and record review, the facility failed to ensure residents admitted to the facility were appropriate for residential care, in that the facility failed to ensure the safety of cognitively impaired residents at risk for elopement, who required 24 hours per day nursing oversight to ensure their safety. One of 3 residents reviewed for elopement in the sample of 3 was documented to have eloped from the facility three times within the past eight weeks. On one of these occasions, he was located near a busy street. On two of the occasions, staff were unaware he had left the building. (Resident M) Findings include: Upon entering the free-standing dementia unit/building on 6/8/11 at 11:30 a.m., the front door glass and side panels were observed to be frosted which prevented the person entering from knowing whether or not a resident was near the door as they opened it. During the orientation tour of 6/8/11 at 11:30 a.m. Resident M was identified by	R0002	**R 002 It is the practice of this provider to ensure that residents admitted to the facility are appropriate for residential care and that the safety of cognitively impaired residents at risk for elopement receive the nursing oversight to ensure their safety, however in response to the 2567 findings the following measures and corrective actions have been taken: Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:** Resident M was found approximately 6 steps away from the door that he had exited from and he was safely assisted back into the campus. A one on one staff member was assigned to Resident M to monitor his whereabouts and safety. The residents Family and Physician were immediately notified of the event. The following morning Resident M was transferred to Hancock Memorial Hospital's Geri-Psych unit for treatment and evaluation. The campus was notified by the family that upon discharge from the Hospital that Resident M would not be returning and that	07/08/2011

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	the Facilitator on the dementia unit as being an elopement risk. She indicated he had successfully scaled a fence in the unit's courtyard. A visitor had seen him climbing the fence and informed the staff. He was located near a busy street which borders the complex in which this facility is located. She indicated he consistently pushed on exit doors to see if he could open them. He was observed during the orientation tour near the main entrance to the building. He was pushing gently on the door, testing to see if it was locked. There were seven exits to this building. Resident M's clinical record was reviewed on 6/8/11 at 12:30 p.m. It indicated his diagnoses included, but were not limited to, Alzheimer's dementia with delusions and behavioral disturbances. He had been admitted the this residential, secured, dementia unit on 4/4/11. Observation and review of the nursing notes and social service progress notes indicated he had eloped three times: A. On 4/14/11, he pushed past a visitor as she entered the front door. She alerted staff and they offered the resident a "walk." He was accompanied both on foot and via a van. He refused a ride. Eventually he accepted a ride in a Sheriff's		they had made other living arrangements for him in a secured memory care unit. Completion: 06/09/2011 **Identification of other residents having the potential to be affected by the same alleged deficient practice and the corrective actions implemented:** All cognitively impaired residents at risk for elopement, have the potential to be affected by the alleged deficient practice, however none were affected. **Measures implemented and systemic changes made to ensure that the alleged deficient practice does not recur:** A keypad has been added to the service hallway entrance. Staff will use the service hallway door to enter as well as exit the facility to limit the use of the front door and the attention give to this as a way for exit seeking residents to exit the campus. Staff members working on the secured memory care unit have been re-educated on the priority of quick response to door alarms to ensure the safety of exit seeking residents. Service plans and C.N.A. assignment sheets for cognitively impaired residents with exit seeking behaviors have been updated to include individualized interventions to redirect behavior. Service Plans will be updated quarterly and or with a change of condition. In-service and re-education had	

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	car back to the facility when staff bargained with him for a cigarette. B. On 5/26/11, he unsuccessfully tried to push out the front door when a peer's family entered. Staff redirected him to the patio area where he could be outside. The same visitor then alerted staff she saw the resident climbing the fence in the courtyard. By the time staff got there, Resident M was gone. Staff in the main building alerted the dementia unit they saw Resident M in the parking lot. Interview with the Facilitator 6/8/11 at 12:10 p.m. indicated Resident M was located near Cumberland Street which borders the complex. Observation of this fence on 6/8/11 at 12:30 p.m. indicated it was eight feet high with a solid brick ledge about three feet above the ground and metal fencing above the brick. Oblong planters were located on either side of the fence which the Facilitator indicated had been added since 5/26/11 to deter further climbing of the fence. The Facilitator listed the following interventions developed after the 5/26/11 elopement: * Residents no longer had free access to the courtyard. They must be staff supervised when there. * The flower planters had been installed		been conducted for staff on exit seeking behavior and elopement guidelines. Potential residents will be assessed by the Legacy Neighborhood Director prior to move-in to ensure that the resident is appropriate for residential care and that an appropriate service plan is developed upon admission to ensure the safety of cognitively impaired residents at risk for elopement. **How the corrective action will be monitored to ensure the alleged deficient practice will not recur:** The IDT will review all new move-ins as well as any change in conditions or behaviors of residents during the daily change of condition meetings to ensure appropriate interventions have been implemented. The Legacy Neighborhood Director or her designee will conduct Elopement drills on a weekly basis for 6 weeks, and then quarterly thereafter. Staff response will be monitored with appropriate counseling and or re-education as necessary. Results of the elopement drills will be reported to the Governing Quality Assurance committee monthly for one (1) quarter and quarterly thereafter.	

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	* The daughter who lived locally was encouraged to visit frequently * The daughter brought in a television and movies the resident was known to enjoy * A physician order was received to offer the resident a glass of wine to redirect him after lunch and dinner C. On 6/8/11, the front door to the dementia unit, the front lobby and the unit dining room were under continuous observation between 12:30 p.m. and 3:45 p.m. Resident M was observed walking to this exit at least twenty times during this period, testing the door to see if it was locked or not. Staff were with him and/or right behind him about 80% of these times. His facial expression remained intense. He wore a smile most of the time, but was determinedly focused on the door. Resident M was observed to be very steady on his feet and appeared strong and healthy physically. When staff tried redirecting him away from the area, he walked stiffly and leaning backwards as though resistive to going with them. He was especially attentive to the door when staff or visitors were entering or leaving the unit, obviously rushing to the door. He was resistive to staff attempts to redirect him to activities or the courtyard. On one door visit while alone, he was observed to reach up and			

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	fidget with the red light above the door which indicated when the door was locked or unlocked. He pushed it, tried to turn it side to side and jiggled it, but abandoned it when the door still did not open. He did not appear to have any physical problems while doing this stretching, balancing, etc. Staff were alerted to this observation. Resident M was offered and accepted a glass of wine at 3 p.m. At 3:25 p.m. a visitor exited through this door without staying to make sure it closed securely. Resident M was observed running for the door and caught it before it relocked. He held it open about an inch until it started alarming and then ran out the door. The alarm continued to sound about 15 seconds and no staff were observed responding to the signal, so the Facilitator was alerted. She went after him immediately, but he would not return. A dietary aide was told of the problem and he went out. He then came in and alerted more staff. After about 10 minutes, four staff were observed strongly encouraging/pushing Resident M back into the facility through the front door. He was not smiling, and was obviously resistive to re-entering the building. Interview with the Facilitator on 6/8/11 at 12:10 p.m. indicated this residential unit utilizes the Service Plan and nurse aide			

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	assignment sheets as the plan of care. The most recent Service Plan was dated 5/23/11. It had a notation "5/25/11 exit seeking behavior. 15 minute observation checks until IDT (Interdisciplinary Team) deems res (resident) can safely be removed from checks." The current nurse aide assignment sheet for Resident M noted, "High exit seeking risk. Set up shower and clothes, supervision only with the shower once set up." These forms lacked actual interventions into this behavior. Interview with the Director of Nursing and the Administrator on 6/8/11 at 5:30 p.m. indicated Resident M was now receiving 1:1 staff observation and the physician had been called. This residential finding relates to complaint IN00091241.			

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R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on observation, record review and interview, the facility failed to develop service plans for 3 of 3 residents reviewed for exit seeking behaviors in the sample of 3 which reflected the residents' demonstrated needs. (Residents B, K and M) Findings include:	R0217	**R 217** **It is the practice of this provider to develop service plans for each resident to identify the individualized plan of care for each resident, however in response to the 2567 findings, the following measures and corrective**	07/08/2011

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	During orientation tour on 6/8/11 at 11:30 a.m., the dementia unit was observed to be in a free standing building, completely separated from the rest of the facility. Ten residents were identified by the Facilitator as having wandering behaviors. Three were sampled for survey. The Facilitator also indicated this residential unit used the resident's Service Plan and the nurse aide assignment sheets as the plan of care. 1. Resident M's clinical record was reviewed on 6/8/11 at 12:30 p.m. His diagnoses included, but were not limited to, Alzheimer's dementia with delusions and behavioral disturbances. He was admitted to this facility on 4/4/2011. He had eloped from the building twice:, 4/14/11 by going out the front door when a visitor entered and 5/26/11 by climbing over an eight foot fence in the courtyard. He was observed during this visit 6/8/11 to elope out the front door at 3:30 p.m. after having tested the door approximately twenty times between 12:30 and 3:30 p.m. He was resistive to being brought back inside. The temperature was 93 degrees per the car thermometer. The most recent Service Plan was dated 5/23/11. It had a notation "5/25/11 exit seeking behavior. 15 minute observation		**actions have been taken:** **Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:** The service plans for Residents B, K and M, have been updated with an individualized plan of care to include their exit seeking behavior and appropriate interventions. **Identification of other residents having the potential to be affected by the same alleged deficient practice and the corrective actions implemented:** All Residents with exit seeking behavior have the potential to be affected by the alleged deficient practice. **Measures implemented and systemic changes made to ensure that the alleged deficient practice does not recur:** Service plans for cognitively impaired residents with exit seeking behaviors, have been updated to include individualized interventions to redirect	

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	checks until IDT (Interdisciplinary Team) deems res (resident) can safely be removed from checks." The current nurse aide assignment sheet for Resident M noted, "High exit seeking risk. Set up shower and clothes, supervision only with the shower once set up." These forms lacked actual interventions into this behavior. 2. Resident B's clinical record was reviewed on 6/8/11 at 2:45 p.m. It indicated his diagnoses included, but were not limited to, dementia and Schizophrenia. The Facilitator indicated during the orientation tour on 6/8/11 at 11:320 a.m. that Resident B "pushes all doors." He was observed coming to the front door of the unit multiple times between 12:20 p.m. and 3:45 p.m., even with his family discouraging him from doing so and staff trying to redirect him away from the area. He would press on the door and look out the window. The nurse aide assignment/information sheet did not mention his exit seeking behavior. 3. The clinical record of Resident K was reviewed on 6/8/11 at 3:10 p.m. Her diagnoses included, but were not limited		behavior. Service Plans will be updated quarterly and or with a change of condition. Potential residents will be assessed by the Legacy Neighborhood Director prior to move-in to ensure that the resident is appropriate for residential care and that an appropriate service plan is developed upon admission to ensure the safety of cognitively impaired residents at risk for elopement. **How the corrective action will be monitored to ensure the alleged deficient practice will not recur:** Director of Health Services or Designee will audit service plans to ensure that they have been updated to reflect appropriate interventions for new move ins or residents with a change of condition. Results of the service plan audits will be reported to the Governing Quality Assurance committee monthly for one (1) quarter and quarterly thereafter.	

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	to, dementia. She was observed 6/8/11 between 12:30 p.m. and 3:30 p.m. ambulating about the dining room and front lobby area asking about going home. Her nurse aide assignment/information sheet did not mention her exit seeking tendencies nor asking to go home. This residential finding relates to complaint IN00091241.			